Advance Planning Packet

An End-of-Life Decisions Packet for Patients and Families

Getting Started – What Matters Most to You?

The starting point for your end-of-life plan is your own values and priorities. What's important to you? In a situation where you are unable to care for or speak for yourself, what sort of care would you want? What do you not want to happen? As you think about what is important to you should you face this situation, consider the following:

Your Personal Beliefs and Values

How do your spiritual or religious beliefs affect your attitudes about terminal diseases, treatment decisions, or death and dying? Would you want life-sustaining treatments no matter the circumstance, or would you prefer a natural death in instances where recovery is not possible?

Quality of Life Concerns

What basic abilities or functions are important to you in order to feel you would want to continue living? For example, do you feel you must be able to recognize loved ones or communicate with others?

Types of Life-Sustaining Treatments

Are there specific treatments or procedures you know that you would want or definitely would not want if you were diagnosed with a terminal condition and could not make the choice for yourself?

Your Support Network

If you are in a situation where you cannot make decisions for yourself, your support network becomes paramount. Is there a particular provider you want to help your family direct your care? Are there people you do not want involved in your healthcare decisions?

Finally, as you are going through this process, talking to loved ones about your values, priorities, and ultimately your decisions, is an important part of the process to make sure your wishes are followed. By having these sometimes difficult discussions, you help ensure that you receive the care and procedures you established as important if you are ever in a position where you cannot communicate them yourself. Your provider here at Primary Health can help you not only with your decision-making process, but also in helping you have these conversations with your loved ones.

One final note: The State of Idaho has a comprehensive portion of their website dedicated to Health Care Directives that provides the basic forms for Idaho (requirements do vary state to state) and a FAQ section that answers many questions about the process and your rights. Your provider can answer many of these questions as well, but the site is a good reference and resource for the proper forms and Idaho processes for End-of-Life decision-making. The Idaho Advance Directive website can be found at: https://healthandwelfare.idaho.gov/services-programs/birth-marriage-death-records/advance-directives-and-registry-services

The forms available on this site are also available in this packet, but if you prefer to do them on the website you are welcome to do so.

IDAHO HEALTHCARE DIRECTIVE REGISTRY
Your voice. Your choice.

Advance Care Planning

General Guide

Advance Care Planning
The process of discussing and documenting your preferences for future medical care you would like to receive in the event you could not make your own decisions. The best time to make these choices is when you can choose for yourself.

Healthcare Advance Directive
A written plan that identifies and names your healthcare agent and allows you to provide detailed instructions for the type of medical treatment you want to receive in a medical emergency. This document will only go into effect if you cannot communicate your wishes to your medical team on your own.

Healthcare Agent
An individual you trust and give authority to make medical decisions on your behalf at a time when you are unable to make them yourself. Discussing and sharing your wishes for medical care with your agent is important. You can also choose alternate agents in the even your primary agent is not available.

Idaho Healthcare Directive Registry
A secure, web-based platform where you can create, store, and share your Advance Directive online with family members, friends or your healthcare team and is accessible whenever it may be needed. The registry is managed and maintained by the Department of Health and Welfare.

Imagine this scenario:

A life-threating traumatic event has left you unable to communicate with others, participate in your own daily care, decision making, or treatment planning. Although all care and available treatments are being provided, your doctors have determined your illness and or injury cannot be cured, your death is likely, or your brain function will not return.

Ask yourself:
- *What does "living well" mean to me? If I was having a good day, what would happen on that day? Who would I talk to, what would I be doing? What brings me joy or comfort?*
- *What cultural, religious, spiritual, or personal beliefs might help me choose the care I do or do not want?*

Start Planning:
Plan ahead and have conversations with your family and healthcare provider. Decide what treatments you want in an emergency situation. Name your healthcare agent and discuss your wishes with them. Document these wishes in an Advance Directive and be sure to keep your plan up to date.

Who should I choose as my healthcare agent?
Most people name their spouse, partner, relative or close friend as their agent. What's most important is you trust this person without any doubt. Consider this:
- *Who will honor my wishes and will stand up for my choices even if they or others disagree? Who can make those important decisions on my behalf in difficult or stressful situations?*
- *Who is able to and willing to perform this role, and will they likely be available in case of an emergency?*

See other side for more information

COMMON QUESTIONS

When is my Advance Directive used?

You control your own medical care. If you become unable to speak, communicate, or choose your wishes, your healthcare team will follow the instructions as described in your Advance Directive and as directed by your healthcare agent.

What do I need to make my Advance Directive legal?

You must be at least 18 years old with the ability to understand and communicate your decisions and treatment preferences. It needs to be in writing and should include the following:

- *A completed durable power of attorney for healthcare naming your healthcare agent and living will with instructions for your medical treatment.*
- *Your full name, signature, and effective date of the document. In Idaho, your signature does not need to be witnessed or notarized.*

Where can I find an Advance Directive form?

An electronic form can be completed directly on your Idaho Healthcare Directive Registry account. If you do not have an account yet, visit https://idaho-acp.vyncahealth.com to get started. You can also download an Advance Directive and registration form on the DHW webpage address found here: https://healthandwelfare.idaho.gov/advancedirective. Though many people complete their Advance Directive on their own, if you want help, talk to your healthcare team. There may have a facilitator available to help you.

Can I change my mind?

Yes! You can create or update your Advance Directive at any time. If you make changes, be sure to provide a copy to any person or organization that has the outdated copy. It is recommended that you review your Advance Directive annually, or whenever your health changes.

Where should I keep my completed Advance Directive?

Keep your original copy in an easily accessible place where you keep other important documents. Store an electronic copy in the Idaho Healthcare Directive Registry where it is accessible to authorized family members, friends, and healthcare professionals. You can also provide copies to your healthcare agent, primary care provider, or local hospital.

Is my Advance Directive valid in other states?

Every state has its own requirements for an Advance Directive, though most honor one created in another state. If you spend a lot of time in another state, check on that state's requirements. Keep a copy of your Advance Directive with you when you travel.

IHDR@dhw.idaho.gov

(208) 334-5501

https://healthandwelfare.idaho.gov/advancedirective

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Updated March 2023

IDAHO HEALTHCARE DIRECTIVE REGISTRY
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Advance Care Planning

Terms and Definitions to Know

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Antibiotics
A drug or other medicines that are used to treat infections caused by bacteria or other microorganisms.

Artificial Hydration and Nutrition
The use of IVs or inserting tubes into the patient's mouth, nose, or stomach to provide fluids and nutrients in the event they are unable to eat or drink.

Cardiopulmonary Resuscitation (CPR)
An emergency procedure that involves pressing repeatedly on a person's chest and forcing air through his or her mouth. CPR may also include giving medicine or using special equipment to give electrical shocks to the heart or placing a tube down the throat to help with breathing.

Code Status
Describes the type of emergency intervention *(if any)* that a healthcare team would administer in the event of a patient's heart and/or lungs stop working.

- *Full code means CPR is attempted.*
- *Do not resuscitate (DNR) means CPR is not attempted, but comfort care is.*

Comfort Care
Symptom focused treatment intended to control pain and provide physical and emotional relieve so the patient can be as comfortable as possible. Treatment may include administering oxygen or medications, but does not include breathing machines, artificial hydration, and artificial nutrition. Comfort care can be provided in any setting.

Dialysis
A machine that cleans your blood if your kidneys are not working normally. Healthy kidneys help your body get rid of waste products and extra fluid in your blood.

See other side for more information

Hospice
A team of specialists who promote quality of life when a person nears the end of life. Hospice teams offer relief from the physical, emotional, and spiritual pain that can come with a terminal illness and other conditions. Hospice can be provided in most settings.

Intravenous (IV) Line
A narrow, flexible, plastic tube placed inside a vein using a needle. It is used to deliver artificial fluids, medicine, and blood into the body.

Palliative Care
Specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms of a serious illness. The goal is to improve quality of life for both the patient and the family.

Physician Orders for Scope of Treatment (POST)
A form reserved for people with an incurable or irreversible injury, disease, illness, or the patient is in a persistent vegetative state. A POST is a medical order signed by a healthcare provider which describes specific medical treatment decisions. A POST form is not a replacement for an Advance Directive and does not name a Healthcare Agent. Ask you healthcare provider for more information.

Ventilator
A machine that pushes a mixture of air and oxygen in and out of your lungs to breathe for you. The machine connects a tube that goes through your mouth and down your windpipe at the back of your throat.

For more information about creating an Advance Directive, contact your healthcare team or speak with a representative of the Idaho Healthcare Directive Registry.

IHDR@dhw.idaho.gov

(208) 334-5501

https://healthandwelfare.idaho.gov/advancedirective

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Updated March 2023

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Advance Directive Registration Form

This form is required to add a new Advance Directive or POST form to the registry. Email completed forms to IHDR@dhw.idaho.gov or mail to the address below. If you have questions about completing this form or related documents, please call (208) 334-5501 to speak with a registry representative.

I want to:

☐ Store a copy of my Advance Directive and/or POST form in the Registry.

☐ Replace my previously registered Advance Directive and/or POST form with the one provided.

☐ Revoke my Advance Directive and/or POST form from the Registry.

The personal information provided with this request is to store my Advance Directive and/or POST form in the Idaho Healthcare Directive Registry. I certify the document(s) that accompany this agreement is my effective healthcare directive executed in accordance with State of Idaho laws.

I understand that registry use is entirely voluntary and not required. Registration only makes these documents more accessible to healthcare professionals and the individuals that I choose.

REGISTRATION CONFIRMATION WILL BE SENT TO THE REQUESTOR VIA EMAIL ONLY
PAPER DOCUMENTS WILL NOT BE RETURNED

Fill in this registration form and email/enclose it with a COPY of your Advance Directive and/or POST form.

First Name, Middle Name, Last Name * required		Date of Birth * required
Address * required		Gender (M/F/other)*required
City, State, Zip Code * required	Phone * required	Last Four SSN *(optional)*
Email Address * required and cannot be used by another registrant. If no email, enter "none"		

*Fill in **ONLY IF** this registration form is being completed by someone other than the individual listed above.*

First Name, Last Name		
Address		City, State, Zip Code
Phone	Email Address	

_____
Signature of Registrant

_____
Date

Idaho Healthcare Directive Registry
450 W State Street, 4th Floor
Boise, Idaho 83702-0036

IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: _____ **Phone Number:** _____

Address: _____ **Birth Date:** _____

An Advance Directive is a general term used to describe this document. There are two parts: 1) the Durable Power of Attorney for Healthcare and 2) the Living Will. The purpose of this form is to help you plan ahead so your loved ones and healthcare team know what care you want if you experience a medical crisis and cannot speak for yourself.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT.** I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Advance Directive:

Name of Healthcare Agent: _____

Relationship: _____ Phone Number of Healthcare Agent: _____

Address: _____

2. **DESIGNATION OF ALTERNATE AGENTS.** If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Advance Directive (*You are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

A. Name of First Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

B. Name of Second Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

If any of the agents designated above is my spouse, and our marriage is dissolved (divorce or annulment) after creation of this Advance Directive, appointment of that agent is automatically revoked as of the date of the dissolution.

None of the following may be designated as your agent or alternate agent:

- *Your treating healthcare provider.*
- *A non-relative employee of your treating healthcare provider.*
- *An operator of a community care facility; or*
- *A non-relative employee of an operator of a community care facility.*

3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** I hereby grant to my agent full authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. My agent shall make healthcare decisions that are consistent with my desires as stated in this Advance Directive or otherwise made known to my agent verbally or in writing. This includes, but is not limited to, my desires concerning obtaining, refusing, or withdrawing life-sustaining care, treatment, procedures. This authority includes following my desires as stated in a living will or similar document executed by me.

4. **INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.**

A. General Grant of Power and Authority. Subject to any limitations in this Advance Directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records.
- Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- Consent to the disclosure of this information; and
- Consent to the donation of any of my organs for medical purposes.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160

through 164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical Information Bureau, Inc. or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information.

5. **SIGNING DOCUMENTS, WAIVERS AND RELEASES.** When necessary to implement the healthcare decisions that this Advance Directive authorizes my agent to make, my agent has the authority to execute on my behalf all of the following:

a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital against Medical Advice"; and
b) Any necessary waiver or release from liability required by a hospital or physician.

6. **PRIOR DESIGNATIONS REVOKED**. I revoke any prior durable power of attorney for healthcare.

Continue to Living Will on next page.

LIVING WILL
Directive to Withhold or to Provide Treatment

This portion of my Advance Directive creates my Living Will which allows me to make choices about any life-sustaining medical treatment I want or do not want. This Advance Directive shall be effective only if I am unable to communicate my instructions and:

A. I have an incurable injury, disease, illness or condition AND a medical doctor who has examined me has certified:

i. That such injury, disease, illness, or condition is terminal; and
ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
iii. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

B. I have been diagnosed as being in a persistent vegetative state.

IF I AM IN ONE OF THE ABOVE SITUATIONS, my choices are as follows: *(Choose Box 1, 2, or 3 below, check the box, and initial the line after the box you checked).*

Regardless of the box chosen, pain and symptom management (comfort care) will be provided.

1. ☐ _____ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started and, if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and hydration.

OR

2. ☐ _____ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and hydration as follows:

*Check **one** box* and initial the line after the box you checked:

A. ☐ _____ Only artificial hydration
B. ☐ _____ Only artificial nutrition
C. ☐ _____ Both artificial hydration and nutrition

OR

3. ☐ _____ If my death is imminent, I want all medical treatment, care, and procedures necessary to sustain my life, including artificial nutrition and hydration.

SPECIAL PROVISIONS (OPTIONAL)

The following are additional statements of my wishes. *Check all boxes that apply and initial on the line after the boxes you checked:*

IF I AM DIAGNOSED AS PREGNANT:

☐ _____ This Advance Directive shall be honored in its entirety during the course of my pregnancy.

OR

☐ _____ I direct the following treatment ☐ shall ☐ shall not be withheld or withdrawn:

_____

_____

_____

OR

☐ _____ My instructions regarding medical care shall have no force during my pregnancy except that my Healthcare Agent is authorized to make such decisions for me.

☐ _____ If I have a medical condition from which I am not imminently dying, and from which I will not likely recover, am unable to think or communicate, and am dependent on others for my care, I do not want life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration. In such condition, I want care to be focused on my comfort.

☐ _____ Other situations as described in the box below *(If needed, attach, and sign additional pages.):*

This section is not required but can be used to describe any additional desires or wishes. For example: no admission to the intensive care unit, time limits to treatment options, and funeral/burial wishes, etc.

IDAHO POST FORM VERIFICATION. *Check one box and initial the line after the box you checked:*

☐ _____ I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Advance Directive. I hereby approve of those orders and make them a part of this Advance Directive.

OR

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

SIGNATURE OF PRINCIPAL. *You must sign this Durable Power of Attorney for Healthcare and Living Will for it to be valid.*

I understand the full importance of this Advance Directive and am mentally competent to make this Advance Directive. No participant in the making of this Advance Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing.

I sign my name below to this Idaho Durable Power of Attorney for Healthcare and Living Will on the date at the beginning of this document.

_____ _____

Signature Effective Date

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTHCARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND ORIGINAL WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

IDAHO POST Form: Portable Medical Orders

Health care professionals should only complete this form after a conversation with their patient or the patient's representative. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Note to Patients: Having a POST form is always voluntary.**

This is a medical order, not an advance directive. For information about POST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: IDAHO

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____ ____ ____ ____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse or is not breathing.

Pick 1

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. Requires choosing Full Treatments in Section B)

B. Treatment Orders: Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

Full Treatment (required if you choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responders ability to to act on orders in this section]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Not discussed or no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

X *(required)* | Date: *(dd/mm/yyyy):* Required | The most recently completed valid POST form supersedes all previously completed POST forms.

If other than patient, print full name:

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care professional authorized by law to sign POST form in state where completed may sign this order]

X *(required)* | Date: *(dd/mm/yyyy):* Required | Phone Number: ( )

Printed Full Name: | License/Cert. Number

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient's Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact.
(Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone Number: Day: ( ) Night: ( )

Primary Care Provider Name: Phone Number: ( )

☐ Patient is enrolled in hospice — Name of Agency:
Agency Phone Number: ( )

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POST orders: (A POST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other

Professional Assisting Healthcare Provider w/ Form Completion *(if applicable)* Full Name:	Date: *(dd/mm/yyyy)*	Phone Number: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
- **Using POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.

  Professional Assisting Healthcare Provider w/ Form Completion *(if applicable)*
  Full Name:
- **Modifying POST form:** This form cannot be modified. If changes are needed, void form and complete a new POST form.
- **Voiding a POST form:**
  - **If a patient or patient representative (for patient's lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker